Supreme Court, U.S.
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NO. 95-1649

IN THE SUPREME COURT OF THE UNITED STATES

OCTOBER TERM, 1995

STATE OF KANSAS,

Petitioner,

v.

LEROY HENDRICKS,

Respondent.

ON WRIT OF CERTIORARI TO THE SUPREME COURT OF KANSAS

BRIEF OF THE ASSOCIATION FOR THE TREATMENT OF SEXUAL ABUSERS AMICUS CURIAE IN SUPPORT OF PETITIONER

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INTRODUCTION

The Association for the Treatment of Sexual Abusers (ATSA) is a non-profit international organization consisting of over 1,100 professionals who specialize in the research, treatment, assessment and supervision of sexual abusers. ATSA's membership is drawn from all fifty states and nine foreign countries. The membership includes the most prominent clinicians and researchers in the field. Clinical membership requires an advanced degree in a recognized mental health profession plus 2,000 additional hours of experience in evaluating and treating sexual offenders. The ATSA Code of Ethics and Standards of Practice is an internationally recognized guide for the evaluation and treatment of sexual offenders.

ATSA appears as amicus curiae to address the Kansas Supreme Court's invalidation of the Kansas Sexually Violent Predator Act, Kan. Stat. Ann. § 59-29a01 *et seq.*, ("KSVPA") on substantive due process grounds. The Kansas court determined that Kansas' law, although requiring proof of a "mental abnormality" or "personality disorder," allows for the commitment of persons who are not mentally ill. This holding is based, in part, on the court's observation that the term "mental abnormality" has no clinical definition, "could not be used appropriately in a formal diagnosis," and is "not a psychiatric or medical term but, rather, a legal term defined in the Act."[1] *In the Matter of the Care and*

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[1]The U.S. District Court in *Young v. Weston*, 898 F. Supp. 744, 750 (W.D. Wash. 1995) concluded in a challenge to a similar Washington State statute that the term "mental abnormality" has "neither a clinically significant meaning nor a recognized diagnostic

Treatment of Hendricks, 912 P.2d 129, 137-38 (Kansas 1996).

ATSA takes no position on the validity of the KSVPA. ATSA is concerned, however, that certain arguments adopted by the Kansas Supreme Court are not consistent with current clinical practices and reflect an incomplete understanding of the diagnostic process. Specifically, contrary to the Kansas court's finding, the KSVPA's operative term "mental abnormality" does have specific meaning to trained mental health professionals which is determined in a manner familiar to those professionals. Second. ATSA is concerned that the Kansas court misconceives the diagnostic process when it dismisses the definition of the term "mental abnormality" as circular. Finally, ATSA wishes to remove the impression left by the Kansas court that sex predators cannot be treated.

ARGUMENT

A. "MENTAL ABNORMALITY," AS DEFINED BY KANSAS' SEX PREDATOR STATUTE, HAS MEANING TO EXPERTS TRAINED IN THE TREATMENT AND ASSESSMENT OF SEX OFFENDERS.

The KSVPA requires, as a precondition to commitment, a judicial finding that the defendant suffers from a "mental abnormality," a personality disorder, or both. The Kansas Supreme Court correctly noted that the term "mental abnormality" is statutory, rather than

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use," is "unrecognized in the psychiatric community" and is of "no value to treatment professionals."

clinical, in origin. The relevant question, though, is not whether clinicians or the legislature created this term, but whether experts in the treatment and assessment of sex offenders can derive clinical meaning from this term. The answer to this latter question is clearly "yes."

1. "Mental Abnormality" is governed by its statutory definition, and its clinical meaning is derived when professionals give it specific content.

While the term "mental abnormality" does not have a clinical definition, the term has been frequently used in mental health law.[2] As a legal term, its application is governed by its statutory definition, as are other legal terms such as "insane," "incompetent," and "gravely disabled."

Like other broad legal classifications of psychiatric or psychological conditions (such as mental illness, mental disorder, mental disease, and mental defect), the term "mental abnormality" becomes clinically meaningful when a psychologist or psychiatrist gives it specific content. Even the universally accepted terms "mental disorder" and "mental illness" are not meaningful if not given further specific content. No mental health professional would, for example, report or testify simply that a particular individual is "mentally disordered" or "mentally ill." Such testimony would be vague, conclusory and devoid of clinical meaning. Psychological or psychiatric reports and testimony speak in terms of a specific diagnosis, usually from the *Diagnostic and*

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[2]*See* e.g., *Humphrey v. Cody*, 405 U.S. 504, 510 n.6 (1972) (permitting commitment of persons dangerous "because of a mental or physical deficiency, disorder or abnormality").

Statistical Manual of Mental Disorders (American Psychiatric Association 4th ed. 1994) ("the DSM-IV"). When given such content in the context of the evaluation of sexually violent offenders, the term "mental abnormality" has a clear meaning to mental health professionals experienced in this field.

2. The process of determining "mental abnormality" is the same as that used to determine whether someone is "mentally ill."

A qualified mental health professional's determination of "mental illness" for purposes of most states' broad civil commitment laws is a two-step process. First, an individual must be diagnosed by a qualified mental health professional as having a specific disorder defined in the DSM-IV or otherwise generally accepted in the field.[3]

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[3]A mental disorder is a "clinically significant behavioral or psychological syndrome or pattern that occurs in an individual that is associated with present distress (e.g., painful symptoms) or disability (i.e., impairment in one or more important areas of functioning) or with significantly increased risk of suffering death, pain, or disability or important loss of freedom, DSM-IV, at xxi. The DSM-IV specifically excludes as mental disorders:

> deviant behaviors (e.g., political, religious, or sexual) and conflicts that are primarily between the individual and society . . . unless the deviance or conflict is a symptom of a dysfunction in the individual . . ..

DSM-IV, at xxii. Mere sexually deviant behavior, thus, does not rise to the level of a mental or sexual disorder.

Second, the professional must determine whether the disorder is of a type and severity that would warrant commitment to a psychiatric hospital. Generally, this involves the professional determining whether the person's mental condition meets the applicable statutory criteria for commitment. Although substantive commitment standards vary from state to state, this process often involves a determination of whether the individual is a danger to himself or others.

The following example clarifies this two-step clinical process: Persons may be civilly committed based upon fears that the patient will harm him or herself. In such a case, the clinician first determines whether the individual suffers from a mental disorder such as a major depressive episode as defined in the DSM-IV 320-327. The clinician then attempts to assess the individual's risk for suicide. This assessment would involve consideration of those factors identified by experts and treatises[4] which are predictive of increased risk for suicide. Common risk factors include advanced age, gender (male), substance abuse and a history of suicide attempts. A major risk factor for suicide is the presence of a personality disorder, DSM-IV 629-674 including antisocial personality disorder, DSM-IV 645-650. Only an individual who both suffers from a specific mental disorder and is determined, through analysis of specific risk factors, to be at high suicide risk would, absent mitigating circumstances, qualify for civil commitment.

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[4]*Clinical Psychiatry for Medical Students* A. Stoudemire (2d ed. 1994); H.I. Kaplan & B.J. Sadock, *Synopsis of Psychiatry: Behavioral Sciences Clinical Psychiatry* (6th ed. 1991).

The interpretation of the legal term "mental abnormality" by experts in the evaluation and treatment of sex offenders follows the same two-step process. First, the clinician determines whether the individual suffers from a mental disorder. The statutory term "mental abnormality," is defined by KSVPA as a "congenital or acquired condition which affects the emotional or volitional capacity which predisposes the person to commit sexually violent offenses in a degree constituting such person a menace to the health and safety of others," Kan. Stat. Ann. § 59-29a02(b). This term would be understood by trained mental health professionals to encompass certain severe forms of paraphilia.

Paraphilias are forms of sexual disorder that are defined in the DSM-IV. The disorders are characterized by recurrent, intense, sexually-arousing fantasies, sexual urges, or behaviors generally involving: (1) non-human subjects; (2) the suffering or humiliation of oneself or one's partner; or (3) children or other non-consenting persons. DSM-IV 522-523. For this disorder to be diagnosed, the fantasies, urges and behaviors must occur over a period of at least six months. DSM-IV 522-523. This criterion eliminates occasional, or situational offenders, and ensures the presence of a chronic condition. Specifically excluded from the diagnosis of paraphilia are unusual sexual behaviors due to mental retardation, dementia, personality change due to a general medical condition, substance intoxication, a manic episode, or schizophrenia. DSM-IV 525. Behavior due to these conditions:

> can be distinguished from a paraphilia by the fact that the unusual sexual behavior

> is not the individual's preferred or obligatory pattern, the sexual symptoms occur exclusively during the course of these mental disorders, and the unusual sexual acts tend to be isolated rather than recurrent and usually have a later age of onset.

Id.[5]

Not all deviant behavior can be classified as a paraphilia, nor does all sexual offending have its root in sexual pathology. Further, not all paraphilias constitute mental abnormalities as defined by the KSVPA. At least three specific forms of paraphilia, however, are described by and encompassed within that term's definition. Two, Pedophilia (DSM-IV 302.2) and Sexual Sadism (DSM-IV 302.84), are specifically included within the DSM-IV. The third, Paraphilia Not Otherwise Specified: Rape (Paraphilia NOS: Rape), is not, but is widely recognized by experts in the treatment and

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[5] A leading psychiatrist in the field of sexual pathology has noted that the disorders from which these offenders suffer are characterized by "compulsive, repetitive, driven behavior, which at times has no rational, logical rewards [and] appears to fit the criteria of an emotional or psychological illness." G.G. Abel & J.L. Rouleau, "Male Sex Offenders" in *Handbook of Outpatient Treatment of Adults* 271 (M.E. Thase et al. eds., 1990). While the defining characteristic of the paraphiliac is sexual behavior, many paraphiliacs also suffer from a wide variety of psychological dysfunctions. Paraphiliacs, in addition to demonstrating deviant sexual arousal patterns, often show impairment of social functioning, various cognitive distortions, and, at times, impaired anger control. J.S. Milner & W.D. Murphy, *Assessment of Child Physical and Sexual Abuse Offenders,* 44 Family Relations 478-488 (1995).

assessment of sex offenders to constitute a legitimate diagnostic category.[6]

The second step of the process is to determine whether the disorder is of the type and severity to merit civil commitment as a sexually violent predator. Just as diagnosis of a mental disorder would typically not suffice to justify civil commitment on the basis of "mental illness," the diagnosis of an individual as paraphiliac would not be sufficient to define an individual as a sexual predator. A paraphilia can be characterized as mild, moderate or severe depending on the number of symptoms present and the degree to which those symptoms impair social functioning. *Diagnostic and Statistical Manual of Mental Disorders* 281 (American Psychiatric Association 3rd ed. 1987)("the DSM-III-R"). Because KSVPA pertains only to persons who have already acted out in a criminal, sexual manner and because the evaluator must conclude that the individual's mental condition "predisposes" him or her to commit further such acts, the forensic determination of "mental abnormality" will in practice always involve moderate or, more often, severe forms of paraphilia.[7]

Kansas' law explicitly requires the clinician to make a determination of dangerousness. As with the determination of suicidal risk, there is a well-established empirical literature that allows an expert, appropriately

[6]G.G. Abel & J.L. Rouleau, "The Nature & Extent of Sexual Assault," in *Handbook of Sexual Assault: Issues and Treatment of the Offenders* 18 (W.L. Marshall et al. eds., 1990).

[7]The DSM-III-R defined a paraphilia as severe where "the person has repeatedly acted on the paraphiliac urge." DSM-III-R 281.

trained in the field of sex offender evaluation and treatment, to assess the risk of reoffense.[8] Significant risk factors for reoffenders include: deviant sexual arousal as measured physiologically, prior sexual offenses, the choice of unrelated victims, the choice of male victims, and the choice of strangers as victims. In addition, the diagnosis of a personality disorder, more specifically the diagnosis of an antisocial personality disorder,[9] has been directly related to recidivism.

Sex offender specialists are able to use the term "mental abnormality" to identify a small subset of sex offenders who have specific paraphiliac disorders and who are at highest risk to reoffend. The process for doing so is indistinguishable from the process used by mental health professionals to determine "mental illness" in the ordinary course of civil commitment proceedings. The process involves using well-established and widely accepted diagnostic criteria in addition to clinically and empirically derived risk assessment procedures.

[8]This empirical literature is summarized in R.K. Hanson & M.T. Bussiere, *Predictors of Sexual Offender Recidivism: A Meta-Analysis*, Monograph of the Solicitor General of Canada, Ministry Secretariat (Cat. No. JS4-1/1996-4E 1996). Using statistical techniques that allow the combining of separate studies, the authors were able to combine 61 different data sets from six different countries, thus examining a total of 28,972 sex offenders.

[9]The presence of an antisocial personality disorder in and of itself is not sufficient to meet the criteria for sexual predator laws. The presence of a diagnosis of antisocial personality with paraphilia, though, is well-established as increasing the person's risk of offending and dangerousness.

B. THE DEFINITION OF "MENTAL ABNORMALITY" IS CONSISTENT WITH THE DIAGNOSTIC PROCESS AND NOMENCLATURE OF OTHER PSYCHIATRIC DIAGNOSES.

The Kansas Supreme Court determined that the definitions of "mental abnormality" and "personality disorder" are essentially tautological or circular; that is, "that certain behavior defines the condition which is used to predict the condition." *Hendricks*, 912 P.2d at 138-39. This conclusion reflects confusion regarding the nature of the diagnostic process and diagnostic nomenclature.

Little is known regarding the etiology of the vast majority of mental disorders. Unlike certain medical conditions, such as leukemia, there currently is no biomedical test to determine the presence of a particular psychiatric or psychological disorder. For this reason, diagnostic nomenclature generally requires that diagnoses are made based upon observed behavior and patient self-reporting. From these objective and subjective data, the mental health professional posits the presence a mental disorder. The data are compared to established diagnostic criteria and a specific diagnosis is made.

The process of diagnosing paraphilias and associated personality disorders is no different from the diagnostic process for any psychiatric disorder. The diagnosis of a major depressive episode, for example, is based on the observation or the report from the patient that he or she is experiencing certain symptomatology including such things as insomnia, loss of appetite, feelings of worthlessness, and fatigue (DSM-IV 327).

Because there are no specific laboratory tests that would allow one to make any specific psychiatric diagnosis independent of observable behavior and a person's self-report, all psychiatric diagnoses must be based on a combination of subjective data, objective data, and inference. To charge that such a process is "circular" would basically dismiss all psychiatric diagnoses and would reduce a diagnosis of depression to the following: X acts depressed; X must be suffering from depression, which is why X acts depressed.

Because the definition of mental abnormality is consistent with the diagnostic process and nomenclature of other psychiatric diagnoses, the implications of invalidating the KSVPA on this basis would be profound and far-reaching.

C. SEX OFFENDERS CAN BE TREATED.

To the extent that the Kansas Supreme Court's opinion suggests that no treatment for sex offenders exists, it is misinformed. It is true that sex offenders currently cannot be "cured." No "cures" exist for innumerable recognized medical and psychiatric conditions (e.g., AIDS, diabetes, schizophrenia). There is increasing evidence, though, that state-of-the-art treatment programs developed over the last decade significantly reduce recidivism.[10] In fact, recent

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[10] J.K. Marques, et al., *Effects of Cognitive-Behavioral Treatment on Sex Offender Recidivism*, 21 Criminal Justice and Behavior 28, 28-52 (1994); W.L. Marshall & W.D. Pithers, *A Reconsideration of Treatment Outcome with Sex Offenders*, 21 Criminal Justice and Behavior 10, 10-27 (1994); J.V. Becker & J.A. Hunter, Jr., *Evaluation of Treatment Outcome for Adult Perpetrators of Child Sexual Abuse*, 19 Criminal Justice and Behavior 74 (1992); W.L. Marshall & H.E.

research suggests that treatment might be most effective for high risk offenders.[11] The fact that there is no currently known cure for the disorder or that a condition may be difficult to treat does not make it any less a disorder, nor does it suggest that no treatment methods exist that can control the symptoms and/or complications from these disorders. Indeed, psychiatric hospitals have long been home to many whose conditions are not now curable.

CONCLUSION

While ATSA takes no position concerning the KSVPA or its policy implications, it submits this brief in an effort to assist the Court in understanding certain theoretical and scientific issues involved in this case. Kansas' statute uses terms and definitions which, when applied, have meaning to mental health professionals trained in the treatment and assessment of sex offenders. These terms, used in conjunction with the empirical literature on the subject, allow such experts to identify a small population of very dangerous offenders who suffer

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Barbaree, "Outcome of Comprehensive Cognitive-Behavioral Treatment Programs," in *Handbook of Sexual Assault*, ch. 21 (W.L. Marshall, et al. eds., 1990); W.D. Pithers, "Relapse Prevention with Sexual Aggressors," in *Handbook of Sexual Assault*, ch. 20 (W.L. Marshall et al. eds., 1990) and other authorities cited in these sources. G. Hall "Sex Offender Recidivism Revisited: A Meta-analysis of Recent Treatment Studies," 63 *Journal of Consulting & Clinical Psychology* 802-809 (1995). A. Gordon & T. Nicholaichuk, "Applying the Risk Principle to Sex Offender Treatment," 8(2) *Forum on Corrections Research* 36-38 (1996).

[11] A. Gordon & T. Nicholaichuk, "Applying the Risk Principle to Sex Offender Treatment," 8(2) *Forum on Corrections Research* 36-38 (1996).

from identifiable sexual pathologies and display recognized risk characteristics, and thus, are likely to reoffend.

Respectfully submitted,

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